DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
2300 E STREET NW
WASHINGTON DC 20372-5300

IN REPLY REFER TO

6320
Ser 32/0004
8 Feb 00

From: Chief, Bureau of Medicine and Surgery

Subj: SERVICE SPECIFIC IMPLEMENTATION PLAN FOR PRIMARY CARE MANAGER (PCM) BY NAME

Ref: (a) OASD(HA) memorandum of 3 Dec 99
(b) BUMED (MED 03) e-mail ltr of 3 Jan 00

Encl: (1) MTF feedback summary
(2) Implementation Guidelines

1. "PCM by name" is the right thing to do. It creates a dynamic relationship of shared responsibility between an individual provider and a single patient focused on health and wellness. It also links that same provider to a specific panel/population of patients creating an opportunity to understand and influence the global level of health in that population. "PCM by name" is the centerpiece of the Population Health Improvement plan. Over the course of the year we will implement this concept to the greatest extent possible.

2. Reference (a) requires that each Service develop a plan to implement this policy. This letter will serve as the initial Service specific plan for Navy Medicine recognizing that a large portion of the detail will depend upon further collaboration between the Services, TRICARE Management Activity (TMA), the Lead Agents and the Managed Care Support Contracts (MCSC). We realize there will be further clarification and modification to this plan as we identify and overcome the evolving issues.

3. Enclosure (1) contains feedback from over 60% of the Military Treatment Facilities (MTFs) in response to reference (b). This information has helped us provide the initial guidance on some of the issues. The IM/IT requirements and logistics of making this policy happen are the most critical issues from the technical standpoint, but as these are resolved, the functional changes related to care delivery will become our principle concern. These complex technical problems have global, as well as regional and MTF specific components. We will be working with you and your representatives as much as possible. Because many of the solutions are under development, please refrain from major re-engineering efforts or other expensive local initiatives. A TMA working group with Service and Lead Agent representation will be developing this guidance.

4. There are a number of concrete steps you must take now to prepare for reaching the goal of enrolling all Prime enrollees to a PCM by name/supported by a team by 30 September 2000. Enclosure (2) provides initial guidelines for this implementation. Many hurdles including training, education and contract modifications will need to be overcome. These issues need identification and a plan for their resolution.

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5. One of the major areas of focus for the 14 March Optimization "kick off" meeting will be "PCM by name". It will be through this forum and the anticipated follow on meetings and VTC s that we hope to work collaboratively through this transition. My point of contact remains CDR Richard Stoltz who can be reached at rfstoltz@us.navy.mil, fax (202) 762-3133, or phone (202) 762-0926.

6. As I have noted, implementing the "PCM by name" policy is pivotal in making Tricare work. It will provide us with rich opportunities to optimize the relationship between the patient and the provider. I appreciate your responsiveness and hard work on this issue.

D. C. ARTHUR
Assistant Chief for
Health Care Operations

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FEEDBACK FROM MTFs ON PCM BY NAME

1. Concerns about IM/IT issues. These concerns centered around:

- The current CHCS Database is not current.
- MCP is not being fully activated.
- The method of matching an enrollee to a PCM by name.
- How to make the massive transfer from current enrollees assigned to a group to current enrollees being assigned to a PCM by name.
- How labor intensive it would be to make these changes one by one.
- The difficulty in batch enrolling/dis-enrolling.
- Portable Electronic Data Exchange (PEDE) may not have capacity limits to prevent providers from being overbooked.
- The difficulty in keeping track of all the PCM moves and changes and informing beneficiaries of those changes.
- The need for training in the MCP module.
- How the algorithm for appointing to the patient's PCM first, PCM team second, and other appropriate PCM team third will work.
- How to keep an enrollee assigned to a PCM from easily getting appointments with another PCM.

2. Questions regarding how to determine the enrollment capacity of PCMs and whether this is to vary based upon type of provider.

3. Questions regarding how the operational forces will be handled.

4. Questions about how to handle the summer months when there is often a major change in PCMs and gaps in the billets of PCMs.

5. Questions about what to do if an enrollee does not like their assigned PCM.

6. Questions about whether enrollees will be able to choose their PCM.

7. Concerns about enrollees being arbitrarily assigned to a PCM by name.

8. Questions about the kind of beneficiary and provider education which will accompany the change to PCM by name.

9. Questions about who will pay for the implementation of this change.

INITIAL GUIDELINES FOR IMPLEMENTATION OF PCM BY NAME

1. By 14 March 00, complete a detailed and comprehensive roster of your PCMs. The roster should include:

a. For each individual PCM

1) PCM name.
2) PCM ID (social security number).
3) PCM group name.
4) Location (clinic name, address and telephone).
5) Specialty (FP,PEDS etc).
6) Start and stopdates (availability and anticipated transfer).
7) Capacity (To be determined by each Command for every PCM, this should be based upon the Optimization Enrollment Model but taking into account Command specific limitations and resource constraints).
8) Restrictions (AD only, >12 years etc, resident/trainee requiring MTF approval for enrollment).

b. For entire Command

1) Listing of all PCM group names with associated PCMs.
2) Standard enrollment instructions for each specialty (FP, PEDS, ADOL etc).
3) Special instruction to be inserted in the PCM change letter sent to every enrollee by MCSC. The exact format for incorporation into a Managed Care Support Contract (MCSC) MOU will be provided as the contract modifications are finalized.

2. Group size may vary from command to command. Ideally the group size should be small enough to maintain the intent of the policy and ensure continuity. After hours coverage may be accomplished with shared responsibility between multiple groups. I will rely on the discretion of the MTF Commander to determine a reasonable size for each command. For enrollment purposes, a PCM may not be assigned to more than one group.

3. Trainees may be PCMs in conjunction with their supervisory staff. The MTF will identify the trainee PCM by placing a restriction on enrollment in the MOU with the MCSCs. The MCSC will only enroll patients to the trainee after the MTF has provided to the MCSC the panel or patients to be enrolled to the trainee. The enrollment in CHCS will be to the resident for the purposes of scheduling and monitoring. A single supervisory staff member will be responsible for the comprehensive health care management of each enrollee in conjunction with the trainee.

4. Operational units will be assigned to the UIC with group assignment to the operational DMIS. The roles of the operational PCMs will need to be explored and clarified. Additionally, the process of enrollment for these operational units will need to be determined.

5. Existing enrollees will need to be linked to an individual PCM. This process will be cumbersome and labor intensive. Since many MTFs have begun this effort, the TMA working group will be looking for best practice methodologies to disseminate as quickly as possible.

6. Accomplishing this task prior to the transition to PEDE (new DEERS), this Summer, will minimize rework and facilitate the enrollment process. Using the Primary Care Provider field in the mini-registration screen may be a temporary solution for identification of an enrollee's PCM at the MTF level. However, at this time there is no automated capability to enroll patients from this field.

7. If you are not already using the CHCS/MCP module to book appointments, you will need to migrate to full utilization of CHCS/MCP. Use of the MCP module is our best tool for managing patient appointing and referrals. It allows for appropriate backup by a team of PCMs and provides a source of accurate appointing and referral data that is consistent across the MHS.

Enclosure (2)